

apparently be totally resistant to physical treatments when other acute reactive psychotic states typically get better quickly if arousal levels are reduced by tranquillising drugs (Lerner *et al*, 1979)? The answer I believe is that hysterical psychoses are pseudopsychoses in the sense that they are generated by ideas and experiences normal in the patient's culture, and they are probably not associated with ego-boundary disturbances. The latter may occur in true psychoses because of abnormal awareness of internally arising stimuli which many authors conceptualise as the result of a defective perceptual filter mechanism (e.g. see Johnson, *Journal*, April 1985, 146, 429–435). In these cases, major tranquillisers probably help firstly by reducing over-arousal when this contributes significantly to defective information processing, and secondly, and more fundamentally, by directly reducing awareness of internally arising psychotogenic stimuli. Although biological mechanisms which may underlie hysterical conversion and dissociation remain a mystery, the resistance of hysterical 'pseudopsychoses' to neuroleptics suggests that they are quite distinct from those mediating true psychotic states. The apparent presence of ego-boundary disturbances as reflected by Schneiderian first rank symptoms may not reliably exclude hysteria, because elements of these may be incorporated into ideas which determine symptoms in hysterical patients who have had previous contact with psychiatry and psychiatric patients.

From the point of view of management, once a hysterical psychosis is suspected, it may be fruitless to persist with aggressive drug treatment to quell excitement. Instead, an effort should be made to understand the reminiscences from which the patient is suffering, and from which he is trying to escape through the vehicle of culturally determined ideas and disturbed behaviour. This may set the scene for effective catharsis through argument, explanation, or ritual, as appropriate to the patient's culture.

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Cavernosal Alpha Blockade: A Treatment for Erectile Impotence

DEAR SIR,

We read with interest Professor Brindley's article (*Journal*, December 1983, 143, 332–337) describing his treatment of erectile impotence. We employed this method at the Repatriation General Hospital, Greenslopes, and found it satisfactory.

We have since adopted modifications to the original treatment which have resulted in improved convenience to the patient. The intracavernosal injection of 30 mg of Papaverine and 1 mg of Phentolamine produces a penile tumescence which results in erection when followed by sexual stimulation within 8 hours of injection.

We have found that apparently intractable cases of impotence spanning two to thirteen years respond well. Patients have been instructed in self-injection after being observed fully at out-patients, and are thus able to become autonomous in their control of the treatment. Some have found that erections occur spontaneously without injections after three or four treatments.

Of 13 men treated this year all except two had excellent results and four did not need injections after a course of 6 cavernosal injections. They were able to maintain spontaneous erections.

Three were diabetic and one of these had no response. One man developed priapism which was successfully treated with a Tru-Cut biopsy needle.

Phenoxybenzamine was not used after 1984 because it was felt the response was not physiological. It caused erection without stimulation and did not subside after intercourse. The papaverine/phentolamine injection allows intercourse after stimulation and subsides spontaneously after it.

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Epilepsy, Psychosis, Kraepelin and Bleuler

DEAR SIR,

I was very interested to read the letter by Stevens (*Journal*, September 1985, 146, 321–322) about 'Epilepsy and Psychosis'. However, I would like to correct the attribution of "formal thought disorder, disturbances of affect and autism" to Kraepelin. He was in fact the one who coined the term "dementia praecox" with all its implications for symptomatology, age of onset and prognosis. This was replaced in 1911 by E. Bleuler's term "schizo-

phrenias" (plural!) with formal thought disorder, disturbances of affect and ambivalence as characteristic symptoms for this group of psychoses.

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BLEULER, E. (1975) *Lehrbuch der Psychiatrie*. 13. Aufl. neubearbeitet von M. Bleuler. Berlin: Springer.

Anorexia Nervosa: Drop-outs from Treatment

DEAR SIR,

In the *Journal*, September, 1985, 147, 265–271,

Szmukler *et al* state, "At this stage, it cannot be assumed that dropping out of treatment is necessarily associated with a poor eventual outcome. It is possible that significant benefit may be derived from only a few treatment sessions or that some patients who are making good progress feel that no further help is required." Is there not a third possibility, namely that, irrespective of eventual outcome, at the time of dropping out patients feel, rightly or wrongly, that they are deriving no material benefit from treatment?

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CORRECTION

The *Correspondence* running heading on page 581 (*Journal*, November 1985) should read *British Journal of Psychiatry*, (1985), 147, 581–587.

A HUNDRED YEARS AGO

Gloucester and the Beginnings of the RMPA

The French psychiatrist, Parchappe, who visited England in 1847, reported on another remarkable innovation at the Gloucester Lunatic Asylum, namely the creation of a small self-governing unit:

"This is quite an exceptional arrangement. The patients who work in the gardens occupy special quarters consisting of a kitchen-refectory with an open fire and a dormitory with 14 beds. The patients live here by themselves; the door is open directly to the gardens and is outside the asylum wall. They are supervised only by the head gardener who lives in a cottage at some distance. They go to bed at 8, get up when they like. They come and go freely just as they wish. If they wish to go into the town they have only

to ask the gardener's permission. The establishment provides them with meat, bread and beer, and the gardener gives them fruit and vegetables; they do their own cooking and run their household for themselves.

The medical superintendent claims that no inconvenience of any kind has resulted from this peculiar arrangement, and this seems to show how very far one can go in introducing into institutions conditions as nearly as possible resembling those of ordinary life."

Reference

Journal of Mental Science (July 1961) Vol. 107, No. 449, p. 613.